



# STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES  
KEVIN W. CONCANNON, DIRECTOR

February 10, 2006

## GENERAL LETTER NO. 3-E-AP-1

ISSUED BY: Deputy Director for Field Operations

SUBJECT: Employees' Manual, Title 3, Chapter E, **RESTRAINT AND SECLUSION POLICY FOR MHIS APPENDIX**, Title page, new; Contents (page 1), new; pages 1 through 8, new; and the following forms:

470-0428	<i>Consent to Treatment</i> , revised
470-4321	<i>Risks, Triggers, Signs and Coping Aids</i> , new
470-4317	<i>Initial Restraint or Seclusion Prescription</i> , new
470-4318	<i>Restraint/Seclusion Monitoring Checklist and Narrative</i> , new
470-4320	<i>Restraint/Seclusion Patient Debriefing</i> , new
470-4316	<i>Restraint/Seclusion Same Day Staff Analysis</i> , new
470-4319	<i>Restraint/Seclusion Next Working Day Team Debriefing</i> , new
470-4322	<i>Restraint/Seclusion Debriefing: Administrative Review</i> , new

### Summary

The purpose of the mental health institutes is to provide a safe therapeutic treatment environment. A goal is to prevent, reduce, and eliminate the use of restraint and seclusion.

This Appendix issues new state-approved forms that are to be used by all state mental health institutes, to document treatment described related to the use of restraint and seclusion. These forms can be modified only with permission of the Office of The Deputy Director for Field Operations.

### Effective Date

Immediately.

### Material Superseded

Destroy all supplies of previous forms used to order and document restraint and seclusion interventions.

### Additional Information

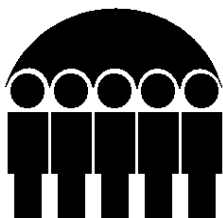
Refer questions about this general letter to your institution superintendent.

February 10, 2006

Employees' Manual  
Title 3  
Chapter E

# **RESTRAINT AND SECLUSION POLICY FOR MHIs**

## **APPENDIX**



Iowa  
Department  
of  
Human Services

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Iowa Department of Human Services

## CONSENT TO TREATMENT

MENTAL HEALTH INSTITUTE  
, Iowa

Granted by / or on behalf of:

Date:

The Mental Health Institute provides active treatment to all patients who are in need of acute psychiatric services. While you are here, treatment will be provided including the use of medications, a psychiatric rehabilitation program, school for children and adolescents, discharge planning, and vocational rehabilitation counseling services.

This consent authorizes the staff of the Mental Health Institute to perform such medical interventions as is necessary for evaluation and treatment and to administer such drugs as in their judgment are necessary for evaluation and treatment. If you are on medications at the time of admission, they may be continued and evaluated by the physician. If other medications are needed at the time of admission, education on these medications will be provided. At the time a treatment plan is initiated, your treatment, including medications will be explained to you. During this treatment planning session, the treatment team will also discuss goals and discharge planning with you. No promise has been made of a successful outcome and medication does not always produce the desired effect, and different medications may be added at a later time. In this case, you will be informed of recommended changes or additions.

Restraint and/or seclusion are used as a treatment of last resort only in an emergency situation at this hospital. Should you become a danger to yourself or others and all other interventions including the recommendations suggested when completing the coping aids forms have failed, you might need to be secluded or restrained.

The Mental Health Institute philosophy of treatment and restraint and seclusion policy have been explained to me and I have received a copy of patient rights materials which outline my rights and responsibilities as a patient.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Guardian (if applicable) \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Consent to Treatment, Form 470-0428**

Purpose	<p>Form 470-0428 is used by the Mental Health Institute to confirm that an individual has given consent for treatment while a patient in the facility. This form also confirms that the patient has been informed of:</p> <ul style="list-style-type: none"><li>◆ The philosophy of treatment of the facility,</li><li>◆ The policy concerning restraint and seclusion, and</li><li>◆ The patient's rights and responsibilities.</li></ul>
Source	<p>This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3S2\DEPDIR.772\FACILITYPOLICY\R&amp;S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop or forms room where available.</p>
Completion	<p>The admission staff shall explain this form to the patient. The patient (or the patient's guardian, where applicable) shall read, sign, and date the form. The patient's signature is required before delivery of treatment other than lifesaving measures.</p>
Distribution	<p>Upon completion, this form is filed in the patient's ward chart while an inpatient in the Mental Health Institute. At the time of discharge, the form is moved to the patient's permanent medical record.</p>
Data	<p>The form contains the patient's name, the date administered, and the signatures of the patient, the guardian, and a witness.</p>

**Risks, Triggers, Signs and Coping Aids, Form 470-4321**

Purpose	<p>Form 470-4321 is intended to identify situations that may lead to agitation of the patient and to identify methods that may be helpful to deescalate a potentially volatile situation.</p> <p>The form is also designed to identify additional self-reported conditions such as medical conditions or history of abuse that should be considered when providing treatment and is to be read and understood by all staff working with the patient.</p>
Source	<p>This form may be printed from the DHS on-line manual, from the electronic share located at \\HOOVR3S2\DEPDIR.772\FACILITYPOLICY\R&amp;S FORMS, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.</p>
Completion	<p>This form is to be completed by the patient or with the patient assisted by admission staff upon admission to the MHI or as soon as possible thereafter when the patient is able to answer the questions on the form.</p>
Distribution	<p>Keep this form readily available in the patient's medical record. Additional distribution of form shall be as designated by MHI policy and procedures on restraint and seclusion.</p>
Data	<p>Encourage the consumer to complete the form. The form lists:</p> <ul style="list-style-type: none"><li>◆ Things that cause agitation, fear, or panic in the patient.</li><li>◆ Observable early warning signs for the patient.</li><li>◆ Things that may help the patient calm down.</li><li>◆ The patient's history of:<ul style="list-style-type: none"><li>• Restraint and seclusion:</li><li>• Medical conditions and physical disabilities.</li><li>• History of sexual or physical abuse.</li></ul></li></ul>

## Risks, Triggers, Signs and Coping Aids

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_

Date: \_\_\_\_\_

1. During your course of treatment, we try to identify and avoid things that cause agitation, fear, or panic. Tell us what kinds of things may set off actions that may lead to a dangerous situation.

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Examples may be:

Being given time limits	Being told what to do	Loud noises or voices	Time of year
Being ignored	Being teased or picked on	Men	Tone of voice
Being told no	Certain people or family members	Time limits	Women
Being touched	Finger pointing	Not having control	Time of the month
Being told to wait	Isolation	Time of day	

2. Are you aware of any observable early warning signs that staff should be aware of that you may exhibit before you start to get upset?

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Examples may be:

Sweating	Loud voice	Can't sit still	Hurting others or things
Breathing hard	Sleeping a lot	Being rude	Hurting myself
Racing heart	Sleeping less	Pacing	Not able to care for self
Clenching teeth	Hyper	Crying	Isolating/avoiding people
Clenching fists	Swearing	Squatting	Laughing loudly/giddy
Red faced	Bouncing legs	Eating less	Singing inappropriately
Wringing hands	Rocking	Eating more	Other

3. What are some things that might help you calm down when you start to get upset?

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Examples may be:

Board games	Drawing	Play doh	Stuffed animals
Bouncing balls	Exercising	Punching a pillow	Talking with someone
Card games	Jigsaw puzzles	Reading	Tearing paper
Collapsible activity toys	Journaling	Relaxation techniques	Time alone
Coloring	Lego blocks	Sitting by self	Video games
Computer	Looking at pictures	Screaming and yelling	Walking
Crafts	Music - listening or playing	Shower or bath	Watching television
Crossword puzzles	Outdoor games	Silly Putty	Wrapping up in a blanket
Crying	Pacing or walking	Squish pillows	Writing stories or letters
Deep breathing	Phone calls	Stress balls	about feelings

4. Have you ever had to be in restraints or seclusion in previous inpatient episodes? ☐ Yes ☐ No  
If yes, please describe where and when:

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5. What happened that resulted in the use of restraint or seclusion.

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6. Do you have any medical conditions or physical disabilities?

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7. Do you have any history of sexual or physical abuse?

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\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



## Initial Restraint or Seclusion Prescription

Restraint or Seclusion is prescribed for no more than \_\_\_\_\_ Hours

Type of Prescription:

Restraint Type:

- |                                    |                                     |  |
|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Restraint | <input type="checkbox"/> Four Point | <input type="checkbox"/> Four Point w / Bicep Cuff |
| <input type="checkbox"/> Seclusion | <input type="checkbox"/> Five Point | <input type="checkbox"/> Five Point w / Bicep Cuff |
|                                    | <input type="checkbox"/> Ambulatory | <input type="checkbox"/> Transport Board           |

Location:

Program / Ward: \_\_\_\_\_

Room: \_\_\_\_\_

Other: \_\_\_\_\_

Where Restrained: ☐ Bed

Reason for Use: ☐ Prevention of Self Harm ☐ Prevention of Harm to Others

Restraint/Seclusion Beginning: Date:\_\_\_\_\_ Time:\_\_\_\_\_ Ending: Date:\_\_\_\_\_ Time:\_\_\_\_\_

Person assessing the need for emergency R/S:

From:(Dr/PAC/ARNP) \_\_\_\_\_ To:\_\_\_\_\_ Read back (if a verbal order):\_\_\_\_\_

Specific reason for prescription: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Interventions attempted to de-escalate the emergency and results:(Include time & staff names) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific Instructions based on the patient's medical or psychiatric condition, history of abuse or R&S history: \_\_\_\_\_  
\_\_\_\_\_

Specific measurable release criteria: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RN / Dr. Signature: \_\_\_\_\_ Date:\_\_\_\_\_ Time:\_\_\_\_\_

Physician/Physician Assistant face to face assessment: Date:\_\_\_\_\_ Time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Signature: \_\_\_\_\_

Iowa Department of Human Services  
**Continuation Restraint or Seclusion Prescription**

Continuation order for: Patient: \_\_\_\_\_ Patient ID: \_\_\_\_\_

Continuation #: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Restraint or Seclusion is prescribed for no more than \_\_\_\_\_ additional hours

From:(Dr/PAC/ARNP) \_\_\_\_\_ To: \_\_\_\_\_ Read back (if a verbal order): \_\_\_\_\_

Specific reason for continuation: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
RN Signature: _____	Date: _____ Time: _____	Medical Staff Signature: _____



Continuation #: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Restraint or Seclusion is prescribed for no more than \_\_\_\_\_ additional hours

From:(Dr/PAC/ARNP) \_\_\_\_\_ To: \_\_\_\_\_ Read back (if a verbal order): \_\_\_\_\_

Specific reason for continuation: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
RN Signature: _____	Date: _____ Time: _____	Medical Staff Signature: _____

Physician/Physician Assistant face to face assessment: Date: _____ Time: _____ _____ _____ _____ _____ _____ _____	
_____	Signature: _____

**Initial Restraint or Seclusion Prescription, Form 470-4317**

Purpose	<p>Form 470-4317 is used to prescribe restraint or seclusion as a last resort to prevent imminent physical harm to either the patient or facility staff.</p> <p>The back of this form is used to continue the restraint or seclusion beyond the initial prescription and describes the specific reasons or behaviors that require the continuation of the restraint or seclusion.</p>
Source	<p>This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3s2\DEPDIR.772\FACILITYPOLICY\R&amp;S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.</p>
Completion	<p>MHI medical staff or an MHI registered nurse completes this form when restraint or seclusion needs to be prescribed.</p> <p>MHI medical staff or an MHI registered nurse completes the back of this form when restraint or seclusion needs to be continued beyond the timeframes of the original prescription.</p>
Distribution	<p>Distribution shall be as designated by MHI policy and procedures on restraint and seclusion.</p>
Data	<p>Complete all items on each form. The form documents:</p> <ul style="list-style-type: none"><li>◆ The reason for the restraint or seclusion.</li><li>◆ The intervention attempted to de-escalate the emergency.</li><li>◆ Specific instructions based on the patient's history.</li><li>◆ Criteria for the patient's release from restraint or seclusion.</li><li>◆ The physician or physician assistant's face-to-face assessment of the patient.</li><li>◆ Orders for continued restraint or seclusion and the reason for those orders.</li></ul>

**Restraint/Seclusion Monitoring Checklist and Narrative, Form 470-4318**

Purpose	<p>Form 470-4318 is used to:</p> <ul style="list-style-type: none"><li>◆ Document the names of all staff directly involved in a restraint or seclusion intervention;</li><li>◆ Describe objective release criteria from the restraint or seclusion prescription form to be used in determining when a patient can be released; and</li><li>◆ Document assessments of the patient's physical and psychological well being during a restraint or seclusion intervention.</li></ul>
Source	<p>This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3s2\DEPDIR.772\FACILITYPOLICY\R&amp;S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.</p>
Completion	<p>This form is to be completed by MHI staff involved in the restraint or seclusion intervention and subsequent monitoring of the patient.</p>
Distribution	<p>Distribution of form shall be as designated by MHI policy and procedures on restraint and seclusion.</p>
Data	<p>Complete all items on each form.</p>

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[illegible]

Time:

### Observation Notes / Narrative

[illegible]



## Restraint/Seclusion Patient Debriefing

Patient Name: \_\_\_\_\_

Patient #: \_\_\_\_\_

Check event that applies: ☐ Restraint ☐ Seclusion

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

1. What events led up to the incident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Did I say or do anything that made the situation worse? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. How did I feel before all of this happened? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. How do I feel now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. What did I want in the first place? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. What actually happened to me as a result? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. What could I try next time that might work better? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. I also want staff to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Signature of RN Supervisor or designee



**Restraint/Seclusion Patient Debriefing, Form 470-4320**

Purpose	Form 470-4320 is used to document information received directly from a patient involved in a restraint or seclusion intervention.
Source	This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3s2\DEPDIR.772\FACILITYPOLICY\R&S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.
Completion	The RN or designee initiates the patient debriefing process. As soon as the patient is receptive following any incident of restraint or seclusion staff will ask the patient to complete this form. The patient can complete the form independently or with staff assistance.
Distribution	Place the form in the front of the patient's medical record for reference during the team debriefing. Additional distribution of form shall be as designated by MHI policy and procedures on restraint and seclusion.
Data	<p>The form solicits information on:</p> <ul style="list-style-type: none"><li>◆ The events leading up to the incident.</li><li>◆ The patient's actions and feelings before and after the incident.</li><li>◆ Possible future strategies.</li></ul>

**Restraint/Seclusion Same-Day Staff Analysis, Form 470-4316**

Purpose	Form 470-4316 is used to document an immediate post-event analysis and discussion by all primary staff involved in a restraint or seclusion intervention. This form is also to be used in the team debriefing and the administrative review.
Source	This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3s2\DEPDIR.772\FACILITYPOLICY\R&S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.
Completion	<p>The RN supervisor or designee initiates the same-day staff debriefing process following any incident of restraint or seclusion, after the situation has calmed, orders are written, and the initial paperwork is completed. To the extent possible, all staff directly involved in the incident shall be included in this debriefing.</p> <p>The debriefing for staff is to be a structured meeting in a safe environment, encouraging an open discussion and recording of the facts and what might have been done differently to avoid this and future incidents of restraint or seclusion.</p>
Distribution	Place this form in the patient's record to document the debriefing results and to be used in the team debriefing and administrative review. Additional distribution of form shall be as designated by MHI policy and procedures on restraint and seclusion.
Data	<p>Complete all items on each form. The form summarizes:</p> <ul style="list-style-type: none"><li>◆ The events that led up to the incident.</li><li>◆ How the situation escalated.</li><li>◆ What staff actions helped and didn't help.</li></ul>

## Restraint/Seclusion Same-Day Staff Analysis

Check event that applies: ☐ Restraint ☐ Seclusion

Restraint/Seclusion: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_

First incident R/S this admission: ☐ Yes ☐ No

Primary staff involved in the intervention:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Staff present for analysis:

_____	_____	_____
_____	_____	_____
_____	_____	_____

1. What events led up to the incident? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How did the situation escalate? (verbal, non-verbal, physical) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What staff actions helped? (verbal, non-verbal, physical) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What staff actions didn't help? (verbal, non-verbal, physical) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Was a PRN or STAT medication given prior/during restraint or seclusion? ☐ Yes (Circle PRN or STAT) ☐ No

1 <sup>st</sup> dose - Time given _____	Medication _____	Dose _____	Route _____
2 <sup>nd</sup> dose - Time given _____	Medication _____	Dose _____	Route _____
3 <sup>rd</sup> dose - Time given _____	Medication _____	Dose _____	Route _____

6. Was staff response time appropriate? ☐ Yes ☐ No

7. Were all needed equipment/supplies immediately available and ready? ☐ Yes ☐ No

8. Were there enough staff to safely manage the situation? ☐ Yes ☐ No

9. Was it clear who was the On-Scene Leader? ☐ Yes ☐ No

10. Comments/ Explain any answers of "No" on questions 6 - 9: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. If there were injuries to patient(s) or staff, indicate who was injured and the type of injuries;  
Identify staff by job title only & other patients by client ID: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. Actions taken to treat injuries (patient or staff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. What went well about the emergency response? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. What could we try next time that might work better? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Recommendations for treatment plan and/or administrative review and other comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Ensure Restraint/Seclusion Intervention is recorded in the treatment plan. ☐ Yes ☐ No

16. Describe the physical and emotional effects on both the consumer and the staff. Have staff or patients  
been informed of how to seek psychological services to cope with this event? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of RN Supervisor or designee

**Restraint/Seclusion Next Working Day  
Team Debriefing**

Patient Name: \_\_\_\_\_

Patient #: \_\_\_\_\_

Check event that applies: ☐ Restraint ☐ Seclusion

Restraint/Seclusion: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

Persons Participating: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this the first incident of R/S this admission? ☐ Yes ☐ No If yes, how often in the past 30 days? \_\_\_\_\_

1. What events led up to the incident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. How did the situation escalate? (verbal, non-verbal, physical) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Review of patient input: (when possible, have patient read or describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Review of recommendations and implementation of changes in treatment plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Notification and debriefing completed with family/significant other(s) by social worker. Person(s) notified: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ No authorization by adult client for notification of family/significant other(s).

\_\_\_\_\_  
Social Worker / Staff Signature

\_\_\_\_\_  
Date

**Restraint/Seclusion Next Working Day Team Debriefing, Form 470-4319**

Purpose	<p>Form 470-4319 assists the treatment team to:</p> <ul style="list-style-type: none"><li>◆ Determine how to more effectively assist the patient and staff in understanding what precipitated a restraint or seclusion event.</li><li>◆ Develop interventions to avoid the need for restraint or seclusion.</li></ul>
Source	<p>This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3s2\DEPDIR.772\FACILITYPOLICY\R&amp;S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.</p>
Completion	<p>The assigned treatment team completes a team debriefing on the next working day following an incident of restraint or seclusion. The meeting shall include the patient, the physician, the nurse, the social worker, and, when possible, LPNs, RNs, and the RN supervisor.</p> <p>The team members indicate on this form whether or not there have been multiple episodes of restraint or seclusion during this admission and how frequently episodes have occurred within the past 30 days. Recommendations include strategies to eliminate multiple episodes and use alternative interventions.</p>
Distribution	<p>File the completed team debriefing form in the patient's record. Additional distribution of form shall be as designated by MHI policy and procedures on restraint and seclusion.</p>
Data	<p>Complete all items on each form. The form contains:</p> <ul style="list-style-type: none"><li>◆ A list of the staff participating in the debriefing.</li><li>◆ A summary of the events heading up to the incident.</li><li>◆ A review of the patient report.</li><li>◆ A review of the recommendations and implementation of changes in the patient's treatment plan.</li><li>◆ Documentation of debriefing with the patient's family.</li></ul>

**Restraint/Seclusion Debriefing: Administrative Review, Form 470-4322**

Purpose	Form 470-4322 is used to document the review by MHI administrative staff of a restraint or seclusion intervention.
Source	This form may be printed from the DHS on-line manual, from the electronic share located at \\Hoovr3s2\DEPDIR.772\FACILITYPOLICY\R&S Forms, or from an MHI public file where available. The form may also be photocopied from an MHI policy manual or obtained from an MHI print shop/forms room where available.
Completion	<p>The clinical director, director of nursing, or the superintendent leads an administrative review of all written debriefing materials following each episode of restraint or seclusion.</p> <p>The reviewers will particularly note if there have been multiple episodes of restraint or seclusion required for this patient, as indicated by the team debriefing form. If so, the administrative reviewers will specifically address causes and strategies to reduce or eliminate future episodes.</p> <p>The recommendations of the administrative review will be routed to and acknowledged by the treatment team, the physician staff, nursing staff, training staff and any other applicable departments of the facility.</p>
Distribution	Distribution of form shall be as noted above and as designated by MHI policy and procedures on restraint and seclusion.
Data	<p>Complete all items on each form. The form identifies:</p> <ul style="list-style-type: none"><li>◆ Any evidence that a site or policy may have triggered the incident.</li><li>◆ Any training needs identified based on the review.</li><li>◆ Any feedback for the patient's treatment team based on the review.</li></ul>

**Restraint/Seclusion Debriefing:  
Administrative Review**

Patient Name: \_\_\_\_\_

Patient #: \_\_\_\_\_

R/S Started: Date: \_\_\_\_\_ Time: \_\_\_\_\_

R/S Ended: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Location: \_\_\_\_\_

Review Team Staff Present: \_\_\_\_\_ (Leader)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ Patient debriefing form reviewed

☐ Same day staff debriefing form reviewed

☐ Next working day team debriefing form reviewed - (If patient has been in restraint or seclusion more than once in the past 30 days – specifically address the causes and plans to eliminate future episodes.)

☐ Is there evidence that a rule or policy may have triggered the incident?

☐ Yes (Indicate the rule and any changes that may have gone into effect since the event)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ None

Training needs identified based on review of information

☐ Yes

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ None

Feedback for treatment team based on review of information:

☐ Yes

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ None

Feedback will be provided by: (Administrative Leader) \_\_\_\_\_

Recommendations acknowledged by: ☐ Tmt team ☐ Physicians ☐ Nursing ☐ Training ☐ Other \_\_\_\_\_

Date and time of administrative review: \_\_\_\_\_